

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

2 0 0 0 — 1 2

2. STATE:

Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 1, 2000

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 435.110

7. FEDERAL BUDGET IMPACT:

a. FFY 2000 \$ -0-

b. FFY 2001 \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 2.6-A, Supplement 1, page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):Attachment 2.6-A, Supplement 1,  
page 1

10. SUBJECT OF AMENDMENT:

Need Standard

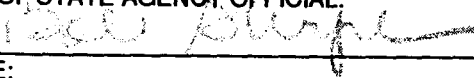
11. GOVERNOR'S REVIEW (Check One):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Currently in review

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Bob Sharpe

14. TITLE:

Acting Deputy Director

15. DATE SUBMITTED:

September 18, 2000

16. RETURN TO:

Mr. Bob Sharpe  
Acting Deputy Director for Medicaid  
Agency for Health Care Administration  
Post Office Box 12600  
Tallahassee, Florida 32317-2600

Attention: Wendy Johnston

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

September 22, 2000

18. DATE APPROVED:

December 14, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Eugene A. Grasser

22. TITLE:

Associate Regional Administrator  
Division of Medicaid and State Operations

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: FLORIDAINCOME ELIGIBILITY LEVELS

## A. MANDATORY CATEGORICALLY NEEDY

## 1. TANF-Related Groups Other Than Poverty Level Pregnant Women and Infants:

## NEED AND PAYMENT STANDARDS

FAMILY SIZE	NEED STANDARD	PAYMENT STANDARD (INCLUDES MAXIMUM SHELTER)
1	696	180
2	938	241
3	1,180	303
4	1,421	364
5	1,663	426
6	1,905	487
7	2,146	549
8	2,388	610
9	2,630	671
10	2,871	733
10*	+242	+62

Adjustment for each addition.

## 1. Pregnant Women and Infants under Section 1902(a)(10)(I)(IV) of the Act:

Effective May 1, 1992, based on the following percent of the official Federal income poverty level--

☐ 133 percent  
(specify)☒ 185 percent (no more than 185 percent)

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	<u>\$ 1,288</u>
<u>2</u>	<u>\$ 1,735</u>
<u>3</u>	<u>\$ 2,182</u>
<u>4</u>	<u>\$ 2,629</u>
<u>5</u>	<u>\$ 3,076</u>
<u>6</u>	<u>\$ 3,523</u>

TN No. 00-12  
Supercedes  
TN No. 99-09Effective Date July 1, 2000  
Approval DEC 14 2000